Must be received by the Benefits Department within 31 days of the qualifying event.

Press Tab to begin filling out the form.

SF 4400-DIS # (4-98)
Supersedes (5-96) issue

The Top Dependent Disenrollment Form

EMPLOYER'S NAME SANDIA NATIONAL LABORATORIES

A. EMPLOYEE INFORMATION:

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOC. SEC. NO.

ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE

B. DEPENDENTS TO BE DISENROLLED:

Spouse's Name	Sex M/F	Birth Date	Social Security Number
Dependent'(s) Name(s)	**Sex M/F**	**Birth Date**	**Social Security Number**

C. REASON FOR DEPENDENT DISENROLLMENT:

- ☐ Marriage, Date:
- ☐ Deceased, Date:
- ☐ Other (please explain):
- ☐ Not Eligible, Date:
- ☐ Divorce, Date:

D.

_____ _____
EMPLOYEE SIGNATURE DATE

TO BE COMPLETED BY EMPLOYER

Effective Date of Termination _____ SNL _____

Sandia Hire Date _____ Rx _____

Return to Benefits Customer Service Center (845-2363), MS 1022, within 31 days of qualifiying event.